IDENTIFYING NAME OR NUMBER OF PLAN: _____

"REIMBURSEMENT" TYPE PLANS

BENEFIT	PREFERRED PROVIDER PLAN		EXPLAIN ANY VARIATION FROM PREFERRED PROVIDER PLAN
MEDICAL BENEFITS	**Participating Provider** (No Annual Deductible)	**Non-Participating Provider** (All benefits payable after annual deductible unless otherwise stated)	
Home, Office, or Office Consultation Visit	90% of Eligible Charges	70% of Eligible Charges	
Hospital Emergency Room Visits	90% of Eligible Charges	90% of Eligible Charges with no annual deductible	
Hospital or Skilled Nursing Facility Intensive Medical Care Medical/Surgical Consultation	90% of Eligible Charges	70% of Eligible Charges	
Well-Child Care Visits • 6 visits from birth through age 12 months (one additional visit is covered when newborn is discharged w/in 48 hours of birth); • 2 visits during age 1; • 1 visit each year during ages 2, 3, 4 and 5	90% of Eligible Charges	70% of Eligible Charges with no annual deductible	
Immunization	100% of Eligible Charges	70% of Eligible Charges	
	100% of Eligible Charges for immunizations in connection with well-child care services; no deductible		

Note: Eligible Charges are based on the lower of the actual charge on the claim, the discounted charge negotiated by the Association, or the charge listed for the service in the Association's Schedule of Maximum Allowable Charges. For a covered service, which does not have a charge, listed in the Schedule, the Association will establish the Maximum Allowable Charge. The Association also reserves the right to annually adjust the charges listed in the Schedule of Maximum Allowable Charges.

"REIMBURSEMENT" TYPE PLANS

BENEFIT	PREFERRED PROVIDER PLAN		EXPLAIN ANY VARIATION FROM PREFERRED PROVIDER PLAN
SURGICAL BENEFITS	**Participating Provider** (No Annual Deductible)	**Non-Participating Provider** (All benefits payable after annual deductible unless otherwise stated)	
Surgery in or out of the Hospital			
Non-Cutting Surgery	80% of Eligible Charges	70% of Eligible Charges	
Cutting Surgery	90% of Eligible Charges	70% of Eligible Charges	
Anesthesiology	90% of Eligible Charges	70% of Eligible Charges	
DIAGNOSTIC LAB, X-RAY FILMS & RADIOLOGY BENEFITS	Out of the Hospital:		
X-Rays	80% of Eligible Charges	70% of Eligible Charges	
Lab Services and Diagnostic Tests	80% of Eligible Charges	70% of Eligible Charges	
Radiotherapy	80% of Eligible Charges	70% of Eligible Charges	
Screening by Low-Dose Mammography • Ages 35-39: 1 baseline mammogram; • Ages 40 or older: 1 per calendar year; • A woman of any age may receive the screening more often if she, her mother, or sister has a history of breast cancer.	80% of Eligible Charges	70% of Eligible Charges with no annual deductible	
HOSPITAL and FACILITY BENEFITS			
Inpatient Care (365 days per calendar year)			
Room and Board	90% of Eligible Charges (Based on semiprivate room rate)	70% of Eligible Charges (Based on semiprivate room rate)	
Intermediate & Isolation Care Units	90% of Eligible Charges	70% of Eligible Charges	
ICU and CCU	90% of Eligible Charges	70% of Eligible Charges	

"REIMBURSEMENT" TYPE PLANS

BENEFIT	PREFERRED PROVIDER PLAN		EXPLAIN ANY VARIATION FROM PREFERRED PROVIDER PLAN
HOSPITAL and FACILITY BENEFITS (continued)	**Participating Provider** (No Annual Deductible)	**Non-Participating Provider** (All benefits payable after annual deductible unless otherwise stated)	
Hospital Ancillary Services (operating room, surgical supplies, drugs, dressings, antibiotics, oxygen, hospital anesthesia services and supplies, etc.)	90% of Eligible Charges	70% of Eligible Charges	
Outpatient Emergency Room (used in connection with medical and surgical services of emergent or urgent nature)	90% of Eligible Charges	90% of Eligible Charges with no annual deductible	
Ambulatory Surgical Center	90% of Eligible Charges	70% of Eligible Charges	
MATERNITY BENEFITS			
Pregnancy, Childbirth or Termination of Pregnancy, and Related Medical Conditions	Regular plan benefits apply for physician, hospital, laboratory, and x-ray services, etc.		
Nurse-Midwife	Regular Medical benefits apply		
Birthing Centers	Regular Hospital and Facility benefits apply		
CONTRACEPTIVE PRESCRIPTION / DEVICES	Varied Co-payments ($10-20%-50%). Co-payments do not count toward the annual co-payment maximum	Varied Co-payments ($10-30%-50%), which does not count toward the annual deductible or annual co-payment maximum	

"REIMBURSEMENT" TYPE PLANS

BENEFIT	PREFERRED PROVIDER PLAN		EXPLAIN ANY VARIATION FROM PREFERRED PROVIDER PLAN
MENTAL HEALTH BENEFITS	**Participating Provider** (No Annual Deductible)	**Non-Participating Provider** (All benefits payable after annual deductible unless otherwise stated)	
In-Hospital Care from a Licensed Physician, Psychiatrist, Psychologist, Clinical Social Worker, Marriage and Family Therapist, Mental Health Counselor, or Advanced Practice Registered Nurse (Up to 30 visits per calendar year.)	90% of Eligible Charges	70% of Eligible Charges	
Inpatient care (30 days per calendar year which count toward 365-day maximum for Hospital Benefits)	Regular Hospital Benefits apply (Treatment of Serious Mental Illness is not subject to the inpatient service limitation)		
Out-of-Hospital Care from a Licensed Physician, Psychiatrist, Psychologist, Clinical Social Worker, Marriage and Family Therapist, Mental Health Counselor, or Advanced Practice Registered Nurse	90% of Eligible Charges Up to 24 visits per calendar year (Treatment of Serious Mental Illness is not subject to the outpatient service limitation)	70% of Eligible Charges	
Psychological Testing			
Outpatient	80% of Eligible Charges	70% of Eligible Charges	
Inpatient	90% of Eligible Charges	70% of Eligible Charges	
	Each outpatient or inpatient psychological testing session shall count against the per calendar year maximum of 24 outpatient visits and 30 inpatient days of facility services.		

"REIMBURSEMENT" TYPE PLANS

BENEFIT	PREFERRED PROVIDER PLAN		EXPLAIN ANY VARIATION FROM PREFERRED PROVIDER PLAN
	Participating Provider (No Annual Deductible)	**Non-Participating Provider** (All benefits payable after annual deductible unless otherwise stated)	
SUBSTANCE ABUSE BENEFITS In-Hospital Care (includes qualified facility operated primarily for detoxification of alcoholics or drug addicts) Out-of-Hospital Care	Regular Hospital and Facility benefits apply Substance abuse benefits have been incorporated into mental health benefits with the same level of benefits; benefits for substance abuse treatment services do not count against the in-hospital and out-of-hospital maximums under mental health benefits.		
SKILLED NURSING FACILITY (120 days per calendar year)	90% of Eligible Charges (Based on semiprivate room rate)	70% of Eligible Charges (Based on semiprivate room rate)	
HOME HEALTH CARE BENEFITS (150 visits per calendar year by qualified home health care agency if physician certifies patient is homebound due to Illness or Injury)	100% of Eligible Charges	70% of Eligible Charges	
HOSPICE CARE	100% of Eligible Charges (For hospice services and hospice referral visits)	Not a benefit	
MEDICAL FOODS	80% of Eligible Charges Co-payments do not count toward the annual co-payment maximum	80% of Eligible Charges with no annual deductible. Co-payments do not count toward the annual co-payment maximum	

"REIMBURSEMENT" TYPE PLANS

BENEFIT	PREFERRED PROVIDER PLAN		EXPLAIN ANY VARIATION FROM PREFERRED PROVIDER PLAN
	Participating Provider	**Non-Participating Provider**	
AMBULANCE BENEFITS (Ground)	80% of Eligible Charges after annual deductible	70% of Eligible Charges after annual deductible	
OTHER MEDICAL BENEFITS:	80% of Eligible Charges after annual deductible	70% of Eligible Charges after annual deductible	
1. Air Ambulance 2. Physical & Occupational Therapy - Inpatient benefit for participating provider is 90% of eligible charges 3. Speech Therapy 4. Allergy Testing & Treatment 5. Blood & Blood Products 6. Appliances and Durable Medical Equipment 7. Chemotherapy for Malignancy 8. Recipient of Transplant Donor Services 9. Outpatient Injections 10. Evaluations for Use of Hearing Aids 11. Dialysis and Supplies			
Maximum Benefits	$1,000,000 lifetime maximum with $10,000 renewal per calendar year per beneficiary		
Deductible	$100 per beneficiary per calendar year or maximum $300 per family per calendar year. The deductible applies to services where indicated.		
Maximum Annual Copayment	$2,500 maximum annual co-payment (portion of Eligible Charges not paid by the plan) per beneficiary per calendar year or maximum $7,500 per family per calendar year including the deductible. Thereafter, Association will pay 100% of Eligible Charges for covered services for the remainder of the calendar year		

"REIMBURSEMENT" TYPE PLANS

BENEFIT	PREFERRED PROVIDER PLAN	EXPLAIN ANY VARIATION FROM PREFERRED PROVIDER PLAN
	Participating Provider **Non-Participating Provider**	
EXCLUSIONS: No benefits will be paid in connection with services not described as covered in the certificate. Summary of exclusions is available upon request. (Please contact Department of Labor and Industrial Relations, Disability Compensation Division at (808) 586-9188.)		